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ABSTRACT

This essay is based on a series of roundtables convened through the Knight Collaborative National Medical Education Roundtable. It reports that the challenges and transformations experienced in recent years by community-based medical schools and clinical campuses offer a lens to the whole higher education enterprise, and asks the fundamental question of how the mission of education and community service can distinguish community health care in an increasingly complex and competitive market. It was expected that community-based medical schools and clinical campuses would help reverse the trend that disproportionately rewarded specialists compared to general practitioners. Increasingly, the search everywhere was for efficiencies and cost savings, giving rise to intrusions that previously would have been unthinkable: third-party payers who decide when treatment is warranted and who will provide it; public plans to ration health care; a reduction in the number of hospital beds; and the rise of for-profit hospitals that promise to use market forces to reduce health care costs. As a result, community-based medical schools and clinical campuses recognize that they have to operate less like institutions whose missions command unrestricted financial support and more like enterprises that generate revenue from their capacity to deliver services at market price. (RH)

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P—O—L—I—C—Y

PERSPECTIVES

The Knight Higher Education Collaborative
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A Lens to the Enterprise

Want to know what will likely happen next to American colleges and universities? Look back at what has happened to hospitals and physicians, then predict accordingly. The parallels are uncanny: Public agencies and corporate employers, alarmed at escalating costs, demand an end to "cost-plus pricing," the practice of simply passing new costs on to consumers without real effort to reallocate or streamline. As the pressures for change mount, there is a conviction that the problem lies with the nature of programs and agencies—too many staff being paid too much and contributing too little—and with the fact that the enterprise has become overly devoted to emerging technologies. Gadgets have become more important than people.

The first attempts at reform are largely regulatory, aimed at controlling costs by eliminating duplication and mandating reasonable prices. When that fails, the powers of the market are unleashed, making efficiency its own reward. Costs are brought under control, but with two largely unanticipated consequences. The purchasers of service, for the most part third-party payers, play an increasingly important role in determining who gets served where, when, and by whom. At the same time, there is a startling rise in the number and power of for-profit providers, enterprises in search of financial rewards commensurate with their capital investment. Sound familiar?

This *Policy Perspectives* builds on that sense of familiarity in search of lessons that have bearing on the strategic choices colleges and universities must make in a world increasingly governed by enterprise rules. Our immediate focus is on the nation's community-based medical schools and clinical campuses, considered both as important educational experiments and as bellwethers of the changing world of higher education.

Also, this *Policy Perspectives* is different in that it derives from a series of roundtables: three convened by individual community-based medical schools or clinical campuses, and a follow-up roundtable bringing together the leaders from these three plus another three community-based medical institutions. In those discussions we found that the challenges and transformations these medical institutions have experienced offer a lens to the higher education enterprise writ large—indeed, we learned that health care has actually done much of what higher education keeps talking about.

The purchasers of service play an increasingly important role in determining who gets served where, when, and by whom. At the same time, there is a startling rise in the number and power of for-profit providers. Sound familiar?

Founding Vision

Most of the nation's community-based medical schools and clinical campuses were established in the 1970s as a relatively low-cost way to increase the supply and improve the distribution of physicians. The issues that concerned health care planners then involved the distribution of health care professionals—the balance between specialty and general practice, and the need to assure a more adequate supply of physicians in rural communities as well as inner cities. Looming before those planners was a projected shortage of physicians able and willing to serve the general needs of a population that was more mobile, that increasingly viewed health care as a right, and that could be expected as it aged to draw more heavily on the full range of health services promised by Medicare.

What was required was a substantial increase in the number of physicians without a substantial increase in cost. What was also required was a coalition of interests that sought a broader geographical distribution of medical education, with sufficient political clout to persuade state legislatures of the benefits of such a step. The founding efforts were substantially aided by a new program of federal capitation grants with the stated purpose of increasing the number of physicians without investing new funds in the infrastructure that inevitably accompanied broad-based commitments to research and hospitals specializing in tertiary care.

We learned that health care has actually done much of what higher education keeps talking about.

While most of these new medical education environments were linked to and frequently seen as part of traditional medical campuses, they were separated by a significant distance from their home schools or universities. The geographical separation could even extend across state lines, as with the partnership between the University of Vermont College of Medicine and the Maine Medical Center. The relationship between these two entities exemplifies the complementary needs that a community-based approach to medical education could fulfill. The University of Vermont's College of Medicine sought a modest increase in capacity to train students in clinical rotations and residencies beyond what its own teaching hospital could accommodate. The Maine Medical Center saw the partnership as an extension of its own mission as both a provider of health care and a trainer of physicians; at the same time, this arrangement offered a means to increase the number of physicians who might ultimately choose to practice in Maine.

During this same period, teaching hospitals, with their connections to their host universities as well as their commitment to instruction in the basic biomedical sciences, were becoming the locus for an explosion of new discoveries that made once-terminal illnesses curable. Given the federal government's massive investment in basic research, university-based schools of medicine led the way in transforming their institutions into research institutes as well as universities. What stirred the imagination within these institutions were the possibilities not just for advancing medical knowledge but also for realizing the individual rewards that result from working on the frontier, whether as a research investigator or as a practitioner of a clinical specialty.

What had been lost in this transformation? Among other things, the sense of purpose and status that had once attached to the general practitioner, the medical generalist who was likely the first physician most Americans expected to see. Major medical schools had come to have a predominant research cast; it was a world in which the grant from the National Institutes of Health (NIH) became the central mark of distinction. The family physician faced the same dilemma as the generalist in other academic fields; while everyone affirmed the importance of those who attained a broad encompassing knowledge, the professional and financial rewards gravitated disproportionately to those who specialized.

Community-based medical schools and clinical campuses were expected to help reverse these trends, making it possible for a larger share of medical education to be practice-based and community-centered. The allotment of student time could vary from one to three years away from the main campus; the common element was the sense of distancing from the research environment of the traditional medical school in order to place medical students in settings more like those where they would actually practice their calling.

Beyond the Founding Vision

Community-based medical schools and clinical campuses are no longer new or news. They have grown, thrived, matured—and, like the traditional medical schools that spawned them, they now find themselves struggling to make sense of a medical landscape whose new contours frequently defy description. Their original raison d'être—a looming shortage of physicians—has been replaced with a growing sense that there is an oversupply of physicians, in the specialties if not in general practice. Even the once defining label of "community-based" is proving illusive as the competition intensifies within the fields of medical education and practice. Indeed, like the well-polished lens they have become, community-based medical schools now exemplify the interplay between vision and reality that roils so many educational institutions.

The family physician faced the same dilemma as the generalist in other academic fields; while everyone affirmed the importance of those who attained a broad encompassing knowledge, the professional and financial rewards gravitated disproportionately to those who specialized.

In the past 25 years, changes have occurred not only in the practice of medicine but in the way that the nation pays for health care, in the ties that bind patients and physicians, and, not least, in the focus of medical education. In federal and state capitals, the feeling of abundance that supported the kind of educational experiments represented in the founding of these community-based medical schools and clinical campuses has long since given way to an austerity that seeks to reduce government expenditures and ensure that the dollars spent yield measurable results. The search everywhere is for efficiencies and cost savings, giving rise to intrusions that a decade ago would have been unthinkable: third-party payers with elaborate mechanisms for deciding when treatment is warranted and who will provide it; public plans to ration health care; a determined effort to reduce the number of hospital beds; and, not least, the rise of for-profit hospitals and their promise to use the market to reduce health care costs and end duplications of service.

As a result, among community-based medical schools and clinical campuses there is a clear recognition that "we will have to do it on our own"—to thrive in a different environment through the art of strategy and the discipline of the market. By themselves they will have to identify what they do best, what they do well, and what they must of necessity relinquish to others. They will have to operate less like institutions whose missions command unrestricted financial support and more like enterprises, which generate revenue from their capacity to deliver services at market price.

Lessons from the Field

These are hard-won understandings, the past decade having been no kinder to community-based medical schools than to other health or education providers. Because these schools and campuses are smaller, of more recent vintage, and still more shaped by a founding vision, their lessons have been more explicit and thus more amenable to sharing not just with other institutions of medical education but with higher education institutions in general.

The need to ensure both clarity and flexibility in a smaller unit's relationship to a parent school or university. Community-based medical schools and clinical campuses operate in a space that is defined by two powerful and very different forces: the workings of the parent university or medical school of which they are part, and the workings of a changing external market for medical education, research, and practice. Maintaining their vitality—and viability—in this environment requires both peripheral vision and the ability to respond to changes from either side. A school or campus in this position must continually "look to its left, look to its right."

In this, as in other complex relationships, each side must know what it needs and must see in the other a ready means of achieving those aims. Physical separation from a parent university or medical school often punctuates the sense of difference in both the main and remote locations, and the challenges of maintaining communication and understanding are

proportionately greater. In addition to the resentment that these smaller schools and campuses often feel in being treated as academically inferior to the larger en-

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tity, there is frequently a perception that the funding for the smaller operation is disproportionately below that which the main school or institution accords to itself.

The University of Oklahoma Health Sciences Center–Tulsa Campus had come to realize that, in addition to these inherent differences, a complex reporting structure made it difficult for the dean of the Tulsa Campus to know which matters to bring before the executive dean of the college (matters of accreditation, curriculum, education, faculty appointments, and teaching appointments) and which matters to bring before the university's provost (all other matters, including budgets, legal affairs, resident programs, practice plan, operations, and personnel). Working to clarify this reporting relationship to the home school and university helped all parties to reaffirm the important role the clinical campus performs for the medical school and the university.

In "looking to its left," a community-based medical school or clinical campus must ensure that its sensors are carefully attuned to its university or school, striking a middle ground between the extremes of being wholly absorbed by its parent institution on the one hand and being isolated from it by the fact of physical separation on the other. The challenge is to retain a measure of autonomy that allows the school or campus to respond to the changing needs and opportunities that arise from its local constituents in terms that are its own but in keeping with those of the larger institution of which it is a part.

The need to resolve the dichotomy in a mission that includes a commitment to research as well as to teaching and clinical practice. Looking to their right, these schools and campuses face challenges from the new realities of health economics—in particular, the prospect of research-based schools of medicine coming to incorporate within their current offerings all that is unique and valuable about the community-based education settings. Community-based schools and clinical campuses are in some respects the liberal arts colleges of the medical landscape: their faculty talk about the personal attention given to students and the quality of the learning environment in the same language used by faculty in colleges and smaller universities with a central teaching mission.

What those faculty are learning is the readiness with which their colleagues at research universities seek to emulate that uniqueness, promising small learning clusters within learning environments that provide more variety, more expertise, more opportunities to stand at the frontiers of both research and practice. It is an argument that can appear particularly attractive in an age when resources—or the absence thereof—drive major decisions about curriculum and program. The appeal to both practitioner and student is the same: Here you can have it all—intimacy cum research, broad-based understanding coupled with specialized insight. Most of those who lead community-based programs and campuses understand well the allure of this appeal, having spent substantial parts of their own careers in the larger medical complexes of research universities. They also understand that the larger research environments cannot in fact deliver the same kind of personal attention and mentorship that occurs in the community-based schools and clinical campuses.

Community-based medical schools and clinical campuses inevitably confront the challenge that is facing all service enterprises, whether for-profit or non-profit, whether engaged in the provision of education, research, or patient care. Meeting that challenge requires an effective set of strategies for maintaining focus, for gauging the vicissitudes of the market, and for matching assets and mission in such a way that the whole amounts to something more than the sum of its parts.

Ironically, perhaps, developing cogent strategies depends first on deciding the importance of research as an institutional focus—as distinct from, perhaps even

opposed to, clinical services. In some instances what had begun as a community-based medical school with a clinical focus has developed a research profile to such an extent that the parent university's Carnegie classification depends on the medical school's continued success in attracting sponsored research. One of the most complex and consequential decisions facing clinical campuses and community-based medical schools is determining to what degree they conceive of their missions as contributing to the creation of new knowledge—and to what degree they are teaching-centered organizations that seek to make substantive contributions to the community and regions of which they are part.

The Southern Illinois University School of Medicine illustrates the extent to which a school's strategic choices entail the balancing of risks, costs, and potential advantages of progressing further toward an identity as a comprehensive health sciences center. The strategic questions for this school have centered on the prospect of consolidating further the university's health sciences resources and programs on a single campus. Should this medical school move the freshman year and basic science faculty from the main campus at Carbondale to the community medical campus at Springfield? Should the school merge with a school of nursing and a school of dentistry, which are located on yet another of the university's campuses? What would be the advantages, the risks, the costs of such actions from the standpoint of the local communities affected, the university, and the state? Would such actions be consistent with the school's mission to train primary care physicians for the state of Illinois? This school and its parent university have understood clearly the array of factors that have bearing on this strategic decision. Ultimately they must determine if the advantages of such consolidation outweigh the opportunity costs of achieving it.

Those campuses seeking to bolster their research environments and thereby recast their institutions may find a variety of other questions guiding their strategies. How much more of their energies and financial resources should they devote to enhancing their research environments? Should they seek to recruit and foster more full-time faculty who pursue research agendas? How should they organize themselves to combine the most compelling elements of both the research and the clinical environment?

The University of Oklahoma Health Sciences Center–Tulsa Campus has addressed these questions and taken steps to supply answers that accord with its own strategic goals. This campus has made a concentrated effort to add a formal research program by funding an office of research and a full-time grants administrator, operating its own independent institutional research review board, creating three $1 million endowed chairs to attract full-time investigators, and coordinating the research interests and publications of the entire full-time and volunteer faculty into a formalized database that is updated semiannually.

These schools have also learned that there is the need for concerted strategy to build an environment that combines clinical and research cultures. Experience has taught that bringing the two cultures into physical proximity does not in itself guarantee a fusion. When Texas A&M University Health Sciences Center was founded, the expectation was that the relationship with its clinical partner—Scott and White, located some 90 miles from College Station in Temple, Texas—would foster substantial collaboration in research as well as clinical education. For many years, however, the Temple campus served primarily as a site for the clinical education of third- and fourth-year medical students, with very little cross-fertilization of scholarship between the two campuses and the two institutions.

In federal and state capitals, the feeling of abundance that supported these educational experiments has long since given way to an austerity that seeks to reduce government expenditures and ensure that the dollars spent yield measurable results.

Only recently have the early dreams of creating integrated research efforts been put into action with the planned relocation of a basic microvascular research program from the main university campus in College Station to the Temple campus as part of a new, larger cardiovascular science center. While both clinical and basic science faculty are exploring additional opportunities for multidisciplinary collaborative initiatives on both campuses, the renewed commitment to such

efforts has also heightened the perennial tension between basic science and clinical faculty and increased concerns about the distribution of resources between the two campuses. With diminishing clinical revenues available to support scholarly activities, both institutions are now challenged to explore ways in which the resources of a public institution and a private enterprise can most effectively be merged to support a common academic mission.

Some community-based medical schools and clinical campuses have addressed the tension between a clinical and a research orientation by defining a research agenda that differs from the biomedical research that is the staple of a traditional university-based medical center. The research undertaken in such instances focuses more often on clinical applications than on basic science. Research questions may focus on issues that are often the concern of schools of public health—studies in fields such as epidemiology and others that embody a societal approach to wellness. The University of Illinois College of Medicine at Rockford, for example, conducts health systems research with organizations located in over a dozen counties in the state on questions pertaining to the public health of a given region. This research is understood both within the medical college and in the regions at large as an extension of the college's mission of clinical education and service to communities.

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The need to develop alternative conceptions of faculty roles, responsibilities, evaluation, and reward. An integral part of resolving the tension between a research and an educational mission is to define the terms by which faculty are appointed, evaluated, and rewarded within an institution. A significant achievement of community-based medical schools and clinical campuses has been to help develop an extended range of models outlining different conceptions of a faculty member's professional roles and responsibilities as well as the responsibilities of the institution to its faculty.

In contrast to traditional medical schools, in which a large proportion of faculty are primarily academic and engage in research, the majority of faculty in community-based schools and campuses have a clinical and teaching orientation. Full-time clinical faculty have inherent difficulty in promotion considerations when viewed from the standpoint of a program with a strong research emphasis. Clinical faculty help to fill a well-defined need to deliver clinical services through the hospitals and clinics that are essential sources of revenue for a medical school. And yet the academic culture stumbles at the conception of a faculty member who engages in teaching and service without also contributing to the advancement of knowledge. These schools and campuses exemplify the need for an expanded conception of the faculty role and for an academic value system that can affirm the merit of faculty achievement that centers more on teaching and service than on expanding the base of scientific knowledge. Indeed, this reality is also emerging in traditional academic health centers beset by shrinking graduate medical education funds and greater clinical demands imposed on faculty by managed care.

Some of these campuses have taken substantial steps to create a different kind of track for faculty whose primary responsibility is to an institution's clinical or teaching mission. For example, the University of Illinois College of Medicine, which includes several branch campuses, has established a "divided" tenurable track, termed the Clinical Track and Research Track. The Clinical Track to tenure is primarily for clinicians whose portfolios include teaching, service, and some research activity. Those who pursue the Research Track are for the most part PhDs and physicians with significant research involvement, primarily through NIH funding. Those in the Clinical Track are also most likely to be involved in research that relates to patient care, educational paradigms, and epidemiology, particularly at the School's Rockford campus. Student evaluations of teaching and a record of solid contribution to the school's service mission figure prominently in the performance evaluations of such faculty.

The Southern Illinois University School of Medicine has taken a further step to make it possible for clinical faculty to develop a long-term professional relationship with an academic institution. This school has created a separately incorporated physicians' group as a financial instrument for paying its full-time clinical faculty, including those who are neither tenured nor on a tenure track. This not-for-profit, university-related entity is funded from the fees collected for the provision of clinical services, and it pays the salaries of both tenured clinical faculty and clinical faculty who are not on a tenure track but want to be associated with a university.

Some community-based medical schools and clinical campuses have addressed the tension between a clinical and a research orientation by defining a research agenda that differs from the biomedical research that is the staple of a traditional university-based medical center.

Both of these examples represent points of gradation between the poles of the full-time tenured or tenure-track faculty member on the one hand, and the adjunct instructor on the other, whose services are contracted course by course without the promise of further institutional commitment. Collectively these examples offer models for an institution that seeks to build a core of committed faculty whose expertise and primary realm of activity do not fully align with traditional definitions of faculty roles and responsibilities. These medical schools and campuses offer promising responses to a set of key questions confronting higher education: What is the range of different commitments an institution can make to its faculty? What is the range of commitments it can ask of its faculty in return? How does an institution assess the contribution of faculty who are not on a research or tenure track? Higher education in general has been reluctant to follow the lead of many medical schools in defining an expanded conception of roles, evaluation criteria, and reward and compensation systems in their relations with faculty.

The need to develop strategic partnerships that help an institution to serve more effectively a local community or region, as well as an extended constituency. For the most part, community-based medical schools and clinical campuses have assumed that smaller is better. For 25 years they have taken pride in their remoteness, believing that separateness encouraged a compactness that in itself became a guarantor of their autonomy. Now, the changing dynamics of medical economics are working against that presumption. Economic survival increasingly means building provider networks of both physicians and hospitals that can explicitly share costs as well as strategically divide their combined share of the medical market. Community-based schools and campuses have adapted well to this changing environment; their actions exemplify the qualitative enhancements that strategic partnerships accord both to the parties directly involved and to the communities served.

For community-based medical schools, the central partnerships are those that provide its clinical settings—hospitals, clinics, physician practices—whether on an individual basis or as part of a system of managed care. The University of Alabama at Birmingham School of Medicine, Huntsville Campus and the Huntsville Hospital System are in the process of forming a limited liability corporation, which lays the foundation for several initiatives that the two entities pursue jointly. The Huntsville clinical campus, for instance, has essentially outsourced its administrative operations for billing and collection to the hospital, resulting in greatly reduced overhead and a significantly enhanced collection ratio. The hospital and clinical campus are also discussing the possibility of partnerships in developing a new ambulatory care clinical center and jointly developing a parcel of land to support the enterprise.

Often a community-based medical school develops partnerships with more than one hospital in a region. While these hospitals may compete fiercely with one another in the provision of tertiary care, their partnerships with the medical school or campus serve to bring them together in a common education and service mission. The linkages between a hospital and a community-based school or campus enhance the quality of medical care provided to a local community or region, and they can be a determining factor in attracting certain kinds of physicians who want an academic role in addition to their primary clinical role.

Partnerships between a community-based medical school or campus and a hospital have also proven to be effective approaches to caring for the indigent—and to meeting the costs of providing quality care in a reasonable way. In a changing environment of Medicaid and managed care, hospitals may at times consider themselves best disposed to provide indigent care without involving a medical school or campus. What these schools and campuses provide hospitals, however, are medical students and residents in various stages of apprenticeship who bring a strong commitment to providing quality care—and who provide that care at less cost than a hospital would otherwise incur in the long run.

The Clinical Track to tenure is primarily for clinicians whose portfolios include teaching, service, and some research activity. Those who pursue the Research Track are for the most part PhDs and physicians with significant research involvement.

Partnership with hospitals is not the only channel through which a community-based medical school or clinical campus contributes to the quality of health care within a community or an extended region. The University of Illinois College of Medicine at Rockford has developed a program that explicitly seeks to attract more of the most capable students in the state's public high schools to pursue careers in family practice medicine. Called the Rural Medical Education Program and funded initially through a state legislative initiative, it admits qualified high school graduates of the state's rural regions if the students will pledge to return to a rural area upon graduation as a family practitioner. Another partnership that the College of Medicine at Rockford has developed provides benefits beyond the boundaries of its home state and nation. This college works with the World Health Organization to provide models for developing countries that seek to establish community-based medical education schools and facilities. Such countries have an acute need for more physicians trained in general practice, and they have found that the model of a community-based medical school answers this need more directly than that of a major medical center that is focused more on biomedical research and specialization.

In many ways the community partnership is the totality of the working relationships a medical school or campus fosters with each of the players whose spheres of interest intersect with its own: hospital, clinic, clinical MDs who serve as adjunct or volunteer faculty, community leaders and elected officials, as well as the parent school or university. The ties among these agents collectively make up the network that helps to ensure the continued vitality of this type of medical school or campus.

The University of Alabama at Birmingham School of Medicine, Huntsville Campus exemplifies the importance of strong community partnership and support. It was the strength and agility of its ties to the local community that enabled what had formerly been the University of Alabama at Huntsville's School of Primary Care Medicine to survive after the University of Alabama at Huntsville had elected to close the school. The prospect of losing this teaching facility and the benefits it provided caused the local MDs, the leadership of the hospital and regional clinics, and the political leadership of the community to unite in an appeal to the state legislature and the state university system to which this small medical school had belonged. The result was that this program continued in a new identity as a clinical campus of the University of Alabama at Birmingham School of Medicine.

Gauging the Value Added

The maturing of the nation's community-based medical schools and clinical campuses is indeed a story worth telling in its own right. It is remarkable to observe, however, how much of their tale sounds familiar and how often their means of resolving dilemmas offer lessons that can apply to all of higher education.

Three of those parallels are worth highlighting specifically. A surprisingly large number of public institutions of higher education are, like these community-based medical schools and clinical campuses, of comparatively recent vintage. Among many younger institutions of higher education in North America it is not at all unusual to have a founding vision and faculty cohort still firmly in control of their institution's future. Like their medical counterparts, these insti-

tutions have also faced changed economic circumstances, altered political landscapes, and new challenges that are only tangentially related to the missions that accounted for their establishment. In a number of states, branch campuses of institutions that once saw their mission as one of outreach and dispersion have subsequently changed their orientation to seek and often attain the status of traditional education providers. As with community-based medical schools and clinical campuses, the challenge lies in making certain that the altered arrangements and recast missions retain the vitality and sharpness that was once their dominant characteristic.

Second, as experiments that have come to full maturity in the last quarter of the twentieth century, the lessons and achievements of community-based medical schools and clinical campuses offer an important insight into the dilemma facing all enterprises that have at their core a set of learned professionals. Originally, most community-based medical schools and campuses were learning organizations that exemplified the value of a small, personalized environment stressing learning by doing. They helped validate the importance of educating practitioners with a broad general knowledge and approach in an age when the greatest rewards accrued to specialists. They offered an opportunity to develop new knowledge on how to improve the well-being of a population and on how to educate physicians. They demonstrated what it meant to build, sustain, and modify partnerships not just with a parent university or school but also with a local community, its hospital and clinics, and its professional and political leadership. They demonstrated the rich and vital opportunities for learning that result from a student's contact with faculty who are independent practicing clinicians, in addition to clinical and research faculty who hold full-time appointments in a medical school.

One of the fundamental questions raised by our roundtables was just how many community-based schools and clinical campuses could still lay claim to that sense of community connectivity. As in the rest of higher education, adapting to an increasingly complex set of realities has made these institutions more complex and varied. For many community-based medical schools and clinical campuses, struggling with this mission drift borne of growing complexity has yielded a reaffirming of basic relationships: with their host communities on the one hand, and with their parent universities on the other. The answer, they seem to be telling us, lies in reestablishing that basic sense of connectivity on which education inevitably depends.

Finally, the recent histories of community-based medical schools and clinical campuses demonstrate just how much modern educational institutions have come to reflect their immediate economic circumstances. For whatever reason, the leaders of these institutions have understood that controlling costs and developing markets capable of sustained revenue generation are their first priorities. They have learned, far better than most other leaders of higher education, that ignoring modern economic realities in the name of preserving educational values is a sure way to condemn those values to extinction. If not all the leaders of the community-based medical schools and clinical campuses who contributed to this issue of *Policy Perspectives* were themselves masters of the market, all of them knew that their own, very personal futures depended on including within their communities men and women who could and would lay claim to that distinction.

In distinguishing themselves from the traditional medical schools that spawned them, community-based schools of medicine know that their smaller size, their relative autonomy from the workings of a parent university, and their hard-won knowledge of how to function effectively on smaller budgets make them inherently more nimble and robust. They have the benefit of feedback loops that are shorter; as a result, changes in the economic vital signs come to their screens more quickly, and the danger of massive financial failure can be averted with fewer and simpler moves.

Still, the fundamental question community-based medical schools and clinical campuses must continue to ask is simply, "How can our missions of education and community service distinguish us in an increasingly complex as well as competitive market?" Can our founding visions and smaller size still sustain us, or must there be more? Can we continue to provide our kind of education and service at affordable costs?

Community-based medical schools and clinical campuses will ultimately be judged by the kind of activities that have become their own signature—the value, that is, of their contribution to the communities and regions of which they are part. To what extent do these schools and campuses fulfill a need that is not cur-

rently met by other models of medical education and practice? In what ways are their graduates different from the graduates of larger, traditional academic medical schools? What qualitative enhancements do community-based medical schools and clinical campuses make to their students' development, and how do they make this contribution? How can these

One program, funded initially through a state legislative initiative, admits qualified high school graduates of the state's rural regions if the students will pledge to return to a rural area upon graduation as a family practitioner.

schools and campuses convey the value of their particular service to a broader constituency? In their most general form, these are the same kinds of questions that smaller institutions of higher education must ask of themselves as they face a changing horizon for maintaining educational and fiscal vitality.

These smaller, community-based schools and clinical campuses will continue to face a complex environment in which the consequences of inattention to shifting circumstances could prove catastrophic. In some ways these schools and campuses are players in a game of chess: although the rules of the game are simple, the possible combinations of movements—the potential strategies and risks to the player—are enormously varied and complex. The challenge to these community-based schools and clinical campuses is not so much to defeat an opponent as to remain a vital player on the board—to ensure that they align themselves in strategic formations with other players in ways that serve the public well-being, and to guard against becoming simply a pawn in another's game, sacrificed without real consideration of the important contribution they make. And that, after all, is nothing more or less than the challenge facing American higher education writ large.

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The essay, "A Lens to the Enterprise," is based on a series of roundtables convened through the Knight Collaborative's National Medical Education Roundtable. Our colleague, Fredric D. Burg, MD, formerly Vice Dean for Education and Professor of Pediatrics at the University of Pennsylvania's School of Medicine, played a central role in both the conception and execution of this special project. As a senior faculty fellow at Penn's Institute for Research on Higher Education from 1996-97, Dr. Burg proposed the concept of a roundtable focusing on the challenges to medical education, and he helped to generate both funding for and national participation in the effort. We are indebted to Fred for his insight and leadership at every stage of this project.

The following individuals participated in the National Medical Education Roundtable and helped to shape the resulting essay:

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Other Perspectives

Every issue of *Policy Perspectives* undergoes an extensive review process that includes participants in a given roundtable, contributing editors, and an array of others who bring expertise on particular subjects. One of the most astute and telling critics of our work is Signe Wilkinson, Pulitzer Prize-winning editorial cartoonist of the *Philadelphia Daily News*. After reading a draft, Signe produces from two to five cartoon sketches that punctuate some element of the essay we have written. These sketches, in addition to the comments she provides in telephone calls or written notes, help us to see ourselves, telling us what we have—and have not—conveyed in a given piece. She approaches the issues as an outsider, an independent thinker who brings both irony and compassion to her view of the world.

Choosing among the sketches Signe sends us is never an easy task, although we ultimately have to bite the bullet and choose just one. The preliminary drawings she provided for this issue, however, were so apt that we decided to feature both of them here, as well as her usual tough-minded commentary. We do this as a long-overdue tribute to Signe, and to the indispensable role she plays as a sounding board to our work.

Dear Greg — Two rough sketches to follow. One on med school/university comparison, one on the clinic vs. research tension.

My question about all this commodification of health and education is what happens to the communities that medicine and education once served. Why would anyone want to volunteer at a hospital run by one of our current medical for-profit companies? Why have a bake sale when proceeds only go to repainting the CEO's Lear jet or adding to the shareholders' dividends?

Likewise with education, when the for-profit, or privatized approach

finally permeates all of education, why would anyone volunteer in a Chris Whittle school—just to save money on his teaching budget so he has more for the executive suspenders fund? What happens to a local public school as a center of community pride and activity when the school is run by a corporation 1,000 miles away in Nashville? And why would anyone give a penny to a university that calls itself "the enterprise"?

Oh, well. Gotta go consume something. Let me know which sketch you prefer. —*Signe*

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